

EXHIBIT E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

- - -
ARTHUR JACKSON, III : CIVIL ACTION - LAW
:
vs. :
:
DELAWARE COUNTY, ET AL : NO. 02-3230
- - -

Media, Pennsylvania
Thursday, February 20, 2003
- - -

Deposition of ARTHUR JACKSON, III, taken
pursuant to notice at the law offices of DiOrio &
Sereni, L.L.P., Front and Plum Streets, Media,
Pennsylvania on the above date, beginning at
approximately 10:30 a.m., before Susan Kaufman, a
Certified Court Reporter and Notary Public.

- - -
KAUFMAN COURT REPORTING
Court Reporting & Video Services
18 Foster Avenue
Havertown, Pennsylvania 19083
(610) 446-9694

1 A. After that, I approached Byrdy again, and indicated
2 to her that I did not want to go through that again.

3 And so she tells me well, bring it in
4 and give it to the guards, and we'll take it and
5 dispense it to you out of the infirmary.

6 All fine and dandy.

7 Q. Okay.

8 A. I bring it in, they lose it. They tell me they
9 lost it, they can't find it. They thought I had been
10 released, so they threw it in the trash.

11 Q. So is this the medical department that lost your
12 medicine or --

13 A. Yes, that's --

14 Q. -- not the guards, or you're not sure?

15 A. Well, I'm not sure, because you have to give it to
16 the guards, and the guards see that it gets up to the
17 main building.

18 Q. Okay. But for some reason, someone lost your
19 medicine.

20 A. Right.

21 Q. And this was the following weekend from the weekend
22 where you brought it in, or is it? I mean you tell me.

23 I thought if I followed your testimony,
24 that you had a problem from the inmates on the one

1 weekend.

2 A. Right.

3 Q. So then you approached Byrdey and she said fine,
4 bring it in, and then we'll dispense it. And then you
5 were told well, that was great, but then they lost your
6 medicine.

7 A. Right. I believe it was the succeeding weekend
8 that that happened.

9 Q. Okay. Then that happened? Then what happened the
10 next weekend, did you bring it in at all.

11 A. No, I wasn't going to bring it in any more. That
12 was too expensive to lose that, to lose that type of
13 medications.

14 Q. Okay. But even though you weren't bringing it in,
15 did you still tell the medical department that you
16 needed it?

17 A. Oh, absolutely.

18 Q. Okay. How did you do that, was that in writing,
19 verbally, both?

20 A. That was verbally. Couple times, the COs -- the
21 inmates go up and tell them that I was back on the bed
22 sweating, shaking, you know, diarrhea, vomiting, the
23 whole deal, and they would take me and take me up to
24 the hospital.

EXHIBIT F

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Deposition of ARTHUR JACKSON, III, taken
pursuant to notice at the law offices of DiOrio &
Sereni, L.L.P., Front and Plum Streets, Media,
Pennsylvania on the above date, beginning at
approximately 10:30 a.m., before Susan Kaufman, a
Certified Court Reporter and Notary Public.

- - -
KAUFMAN COURT REPORTING
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1 weekend.

2 A. Right.

3 Q. So then you approached Byrdy and she said fine,
4 bring it in, and then we'll dispense it. And then you
5 were told well, that was great, but then they lost your
6 medicine.

7 A. Right. I believe it was the succeeding weekend
8 that that happened.

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10 next weekend, did you bring it in at all.

11 A. No, I wasn't going to bring it in any more. That
12 was too expensive to lose that, to lose that type of
13 medications.

14 Q. Okay. But even though you weren't bringing it in,
15 did you still tell the medical department that you
16 needed it?

17 A. Oh, absolutely.

18 Q. Okay. How did you do that, was that in writing,
19 verbally, both?

20 A. That was verbally. Couple times, the COs -- the
21 inmates go up and tell them that I was back on the bed
22 sweating, shaking, you know, diarrhea, vomiting, the
23 whole deal, and they would take me and take me up to
24 the hospital.

EXHIBIT G

ORIGINAL

VOLUME II

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

- - -

ARTHUR JACKSON, III : CIVIL ACTION - LAW

:

vs.

:

:

DELAWARE COUNTY, ET AL : NO. 02-3230

- - -

Media, Pennsylvania

Wednesday, March 12, 2003

- - -

Continued deposition of ARTHUR JACKSON,
III, taken pursuant to notice at the law offices
of DiOrio & Sereni, L.L.P., Front and Plum Streets,
Media, Pennsylvania, on the above date, beginning
at approximately 9:38 a.m., before Marguerite
Contino, a Professional Court Reporter and a
Notary Public of the Commonwealth of Pennsylvania.

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KAUFMAN COURT REPORTING
Court Reporting & Video Services
18 Foster Avenue
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Arthur Jackson, III

1 Q. Well, perhaps that was then. It was just
2 mentioned in your attorney's report, that's why I
3 was asking you.

4 Now let's talk about the insulin.
5 You were taking insulin, I gather from your
6 previous testimony, three times a day?

7 A. Yes, sir.

8 Q. That was your regimen at that time?

9 A. Yes, sir.

10 Q. And did you get it three time a day during
11 your weekend visits to the prison?

12 A. No.

13 Q. How many times did you get it a day at the
14 prison?

15 A. Maximum twice, sometimes once.

16 Q. When you got it twice, what times of the
17 day would you get it?

18 A. About 4:30 a.m., 4:00 to 4:30 a.m.; second
19 dosage at 3 o'clock in the afternoon.

20 Q. And on the day that you fell, did you get
21 that second dosage or not?

22 A. I can't honestly answer that because I
23 don't recall.

24 Q. Do you remember getting the first dosage

Arthur Jackson, III

1 that day?

2 A. I believe I got the first dosage in the
3 morning.

4 Q. And when you would get the insulin once a
5 day when you were at the prison, what time would
6 that be? Would it vary, or was it the same
7 time?

8 A. The morning. It was always a problem with
9 getting the afternoon shot. And the evening shot,
10 I might as well have been in Disney Land looking
11 for it.

12 Q. Did they know that you had three shots a
13 day?

14 A. Yes.

15 Q. How did they know that?

16 A. I indicated to them, gave them the number
17 of Dr. Ebba, who was the physician that was and
18 still is handling my insulin for me. He's a
19 family doctor, he's not a specialist.

20 Q. When were you supposed to get the evening
21 shot at the prison, what time?

22 A. 10 o'clock.

23 Q. I want to take you back to the
24 incarceration for four months in 1998. You

EXHIBIT H

**CROZER-CHESTER
MEDICAL CENTER**

Patient : JACKSON, ARTHUR

CROZER

Med Rec No.: 203-42-8537

SUMMARY ON DISCHARGE

Attending : Nel, Wil, Fum Rav

Adm. Date: 06/04/2000

Dis. Date: 06/07/2000

ADMISSION DIAGNOSIS: Hyponatremia.

PRINCIPAL DIAGNOSIS: Hyponatremia.

SECONDARY DIAGNOSIS:

1. Status post head trauma with subarachnoid hemorrhage and subdural hematoma one week prior.
2. Insulin dependent diabetes mellitus.
3. Hypertension.
4. History of CVA in 1994 with left hemiparesis.

HISTORY OF PRESENT ILLNESS: Patient is a 47-year-old African-American male who was recently admitted to inpatient rehabilitation unit following admission to Crozer Chester Hospital for a right occipital subdural hematoma and right frontal subarachnoid hemorrhage as well as right frontal lobe contusion and right basilar skull fracture. The patient's history is that he fell to the ground approximately one week ago when he incurred the above head injury. He was treated and sent to inpatient rehab. While he was in inpatient rehab he was found to have a sodium of 121 and was, therefore, readmitted to the hospital floor for management of his sodium. The patient denied chest pain, shortness of breath, headache. He complained of some dizziness that had been constant since his fall one week ago. The patient states that he had been drinking 16 eight ounce glasses of fluid daily in order to "flush out" his system. He denied increased thirst despite his diabetes. He denies blurry vision at this time. He had no other symptoms at this time except cramping in his fingers which is intermittent bilaterally which he had had since his fall one week ago.

PAST MEDICAL HISTORY: Significant for CVA in 1994 with a left hemiparesis, insulin dependent diabetes mellitus, hypertension, and the head trauma with subarachnoid hemorrhage and subdural hematoma and basilar skull fracture.

MEDICATIONS ON ADMISSION: Clindamycin 600 mg IV q 6 hours, Pepcid 20 mg PO q 12 hours, Effexor 100 mg PO q 8 hours, Procardia XL 90 mg PO q A.M., Tylenol #3 one to two tablets PO q 4 hours prn pain, Betadine swab to his right ear q 8 hours, Klonopin 1 mg PO tid, Klonopin 2 mg PO q HS, Dilantin 300 mg PO q 8 hours, sliding scale insulin coverage with regular insulin.

EXHIBIT I

Hyponatremia

Author/s: Tom Brody

Definition

The normal concentration of sodium in the blood plasma is 136-145 mM. Hyponatremia occurs when sodium falls below 130 mM. Plasma sodium levels of 125 mM or less are dangerous and can result in seizures and coma.

Description

Sodium is an atom, or ion, that carries a single positive charge. The sodium ion may be abbreviated as Na^+ or as simply Na. Sodium can occur as a salt in a crystalline solid. Sodium chloride (NaCl), sodium phosphate (Na_2HPO_4) and sodium bicarbonate (NaHCO_3) are commonly occurring salts. These salts can be dissolved in water or in juices of various foods. Dissolving involves the complete separation of ions, such as sodium and chloride in common table salt (NaCl).

About 40% of the body's sodium is contained in bone. Approximately 2-5% occurs within organs and cells and the remaining 55% is in blood plasma and other extracellular fluids. The amount of sodium in blood plasma is typically 140 mM, a much higher amount than is found in intracellular sodium (about 5 mM). This asymmetric distribution of sodium ions is essential for human life. It makes possible proper nerve conduction, the passage of various

nutrients into cells, and the maintenance of blood pressure.

The body continually regulates its handling of sodium. When dietary sodium is too high or low, the intestines and kidneys respond to adjust concentrations to normal. During the course of a day, the intestines absorb dietary sodium while the kidneys excrete a nearly equal amount of sodium into the urine. If a low sodium diet is consumed, the intestines increase their efficiency of sodium absorption, and the kidneys reduce its release into urine.

The concentration of sodium in the blood plasma depends on two things: the total amount of sodium and water in arteries, veins, and capillaries (the circulatory system). The body uses separate mechanisms to regulate sodium and water, but they work together to correct blood pressure when it is too high or too low. Too low a concentration of sodium, or hyponatremia, can be corrected either by increasing sodium or by decreasing body water. The existence of separate mechanisms that regulate sodium concentration account for the fact that there are numerous diseases that can cause hyponatremia, including diseases of the kidney, pituitary gland, and hypothalamus.

Causes & symptoms

Hyponatremia can be caused by abnormal consumption or excretion of dietary sodium or water and by diseases that impair the body's ability to regulate them. Maintenance of a low salt diet for many months or excessive sweat loss during a race on a hot day can present a challenge to the body to conserve adequate sodium levels. While these conditions alone are not likely to cause hyponatremia, it can occur under special circumstances. For example, hyponatremia often occurs in patients taking diuretic drugs who maintain a low sodium diet. This is especially of concern in elderly patients, who have a reduced ability to regulate the concentrations of various nutrients in the bloodstream. Diuretic drugs that frequently cause hyponatremia include furosemide (Lasix), bumetanide (Bumex), and most commonly, the thiazides. Diuretics enhance the excretion of sodium into the urine, with the goal of correcting high blood pressure. However, too much sodium excretion can result in hyponatremia. Usually only mild hyponatremia occurs in patients taking diuretics, but when combined with a low sodium diet or with the excessive drinking of water, severe hyponatremia can develop.

Continued from page 1

Severe and prolonged diarrhea can also cause hyponatremia. Severe diarrhea, causing the daily output of 8-10 liters of fluid from the large intestines, results in the loss of large amounts of water, sodium, and various nutrients. Some diarrheal diseases release particularly large quantities of sodium and are therefore most likely to cause hyponatremia.

Drinking excess water sometimes causes hyponatremia, because the absorption of water into the bloodstream can dilute the sodium in the blood. This cause of hyponatremia is rare, but has been found in psychotic patients who compulsively drink more than 20 liters of water per day. Excessive drinking of beer, which is mainly water and low in sodium, can also produce hyponatremia when combined with a poor diet.

Marathon running, under certain conditions, leads to hyponatremia. Races of 25-50 miles can result in the loss of great quantities (8 to 10 liters) of sweat, which contains both sodium and water. Studies show that about 30% of marathon runners experience mild hyponatremia during a race. But runners who consume only pure water during a race can develop severe hyponatremia because the drinking water dilutes the sodium in the bloodstream. Such runners may experience neurological disorders as a result of the severe hyponatremia and require emergency treatment.

Hyponatremia also develops from disorders in organs that control the body's regulation of sodium or water. The adrenal gland secretes a hormone called aldosterone that travels to the kidney, where it causes the kidney to retain sodium by not excreting it into the urine. Addison's disease causes hyponatremia as a result of low levels of aldosterone due to damage to the adrenal gland. The hypothalamus and

low levels of aldosterone due to damage to the adrenal gland. The hypothalamus and pituitary gland are also involved in sodium regulation by making and releasing vasopressin, known as anti-diuretic hormone, into the bloodstream. Like aldosterone, vasopressin acts in the kidney, but it causes it to reduce the amount of water released into urine. With more vasopressin production, the body conserves water, resulting in a lower concentration of plasma sodium. Certain types of cancer cells produce vasopressin, leading to hyponatremia.

Symptoms of moderate hyponatremia include tiredness, disorientation, headache, muscle cramps, and nausea. Severe hyponatremia can lead to seizures and coma. These neurological symptoms are thought to result from the movement of water into brain cells, causing them to swell and disrupt their functioning.

In most cases of hyponatremia, doctors are primarily concerned with discovering the underlying disease causing the decline in plasma sodium levels. Death that occurs during hyponatremia is usually due to other features of the disease rather than to the hyponatremia itself.

Diagnosis

Hyponatremia is diagnosed by acquiring a blood sample, preparing plasma, and using a sodium-sensitive electrode for measuring the concentration of sodium ions. Unless the cause is obvious, a variety of tests are subsequently run to determine if sodium was lost from the urine, diarrhea, or from vomiting. Tests are also used to determine abnormalities in aldosterone or vasopressin levels. The patient's diet and use of diuretics must also be considered.

continued ...

Treatment

Severe hyponatremia can be treated by infusing a solution of 5% sodium chloride in water into the bloodstream. Moderate hyponatremia due to use of diuretics or an abnormal increase in vasopressin is often treated by instructions to drink less water each day. Hyponatremia due to adrenal gland insufficiency is treated with hormone injections.

Prognosis

Hyponatremia is just one manifestation of a variety of disorders. While hyponatremia can easily be corrected, the prognosis for the underlying condition that causes it varies.

Prevention

Patients who take diuretic medications must be checked regularly for the development of hyponatremia.

Key Terms

Blood plasma and serum

Blood plasma, or plasma, is prepared by obtaining a sample of blood and

Gale Encyclopedia of Medicine: Hyponatremia

removing the blood cells. The red blood cells and white blood cells are removed by spinning with a centrifuge. Chemicals are added to prevent the blood's natural tendency to clot. If these chemicals include sodium, then a false measurement of plasma sodium content will result. Serum is prepared by obtaining a blood sample, allowing formation of the blood clot, and removing the clot using a centrifuge. Both plasma and serum are light yellow in color.

Further Reading

For Your Information

Books

- Levinsky, N.G. "Fluids and electrolytes." In *Harrison's Principles of Internal Medicine*, edited by K.J. Isselbacher, et al. Engelwood Cliffs, New Jersey: Prentice-Hall, 1995.

Periodicals

- Fried, L.F. and P.M. Palevsky, "Hyponatremia and hypernatremia." *Medical Clinics of North America* 81 (1997): 585-609.
- Frizzell, R.T. et al., "Hyponatremia and ultramarathon running." *Journal of the American Medical Association* 255 (1986): 772-774.

Gale Encyclopedia of Medicine. Gale Research, 1999.